Complete Summary

GUIDELINE TITLE

U.S. Centers for Disease Control and Prevention (CDC) report regarding selected public health topics affecting women's health.

BIBLIOGRAPHIC SOURCE(S)

CDC report regarding selected public health topics affecting women's health. MMWR Recomm Rep 2001 May 11;50(RR-6):1-48. [79 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Neural tube birth defects(such as spina bifida or anencephaly)
- Human immunodeficiency virus infection/acquired immunodeficiency syndrome (HIV/AIDS)

GUIDELINE CATEGORY

Counseling
Prevention
Risk Assessment

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

1. Folic acid awareness:
    - To communicate public health recommendations that reflect recent research affecting the health of women
    - To recommend strategies for increasing folic acid awareness among women of reproductive age to prevent neural tube birth defects
2. Perinatal human immunodeficiency virus (HIV) prevention:
    - To evaluate a multistate surveillance of perinatal HIV prevention guidelines to:
        - determine the extent to which testing and zidovudine treatment are occurring in clinical practice
        - identify barriers to the universal implementation of the guidelines intended to reduce perinatal transmission of HIV infection
        - make research recommendations
3. Classification of HIV exposure category:
    - To evaluate one method of classification of HIV exposure category for women without HIV risk information and to make related research recommendations

TARGET POPULATION

1. Folic acid awareness:
    - All women of reproductive age
2. Perinatal human immunodeficiency virus (HIV) prevention:
    - Pregnant women with HIV infection or at high risk for infection
    - Infants exposed perinatally to HIV
3. Classification of HIV exposure category:
    - Women with HIV infection without HIV risk information

INTERVENTIONS AND PRACTICES CONSIDERED

1. Folic acid awareness:
    - Promotion of folic acid awareness through health education efforts (e.g., media, interpersonal, during office visits; establishment of comprehensive health policies) to prevent birth defects
    - Education of women and their families regarding pregnancy planning and preconceptional health
2. Perinatal prevention of HIV:
    - Access to and use of prenatal care by all women at risk for HIV infection

- Use of rapid testing methods or expedited turnaround of standard tests for HIV among pregnant women
- Use of antiretroviral therapy, such as zidovudine, in HIV-infected pregnant women

3. Classification of HIV exposure category for women without HIV risk information:
    - Use of statistical adjustments to HIV surveillance data to monitor trends in routes of HIV transmission
    - Behavior surveillance of women (e.g., crack use, injection-drug use, risky sexual behaviors) to improve HIV prevention planning

MAJOR OUTCOMES CONSIDERED

1. Folic acid awareness:
    - Women's awareness of the benefits of folic acid to prevent some birth defects as measured by the Pregnancy Risk Assessment Monitoring System
2. Perinatal HIV prevention:
    - Rates of perinatal transmission of HIV
    - Population-based enhanced perinatal surveillance data:
        - Numbers of HIV-infected women with diagnosis before delivery
        - Proportions of women with a diagnosis who received zidovudine prenatally and intrapartum
        - Proportions of neonates with a diagnosis of HIV who received zidovudine
3. Classification of HIV exposure category for women without HIV risk information:
    - Classification of HIV exposure categories using the Supplement to HIV/AIDS Surveillance (SHAS) tool

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases
Searches of Patient Registry Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Folic Acid Awareness

Women's awareness regarding folic acid was examined using data from the Pregnancy Risk Assessment Monitoring System the (PRAMS), which collects information on maternal behaviors and experiences during pregnancy from projects in 24 states and New York City. Each month, the Pregnancy Risk Assessment Monitoring System selects a stratified, systematic sample of 100 to 250 women who have recently given birth in a particular area from the birth certificates of the infants, and a survey questionnaire is mailed to the selected mothers approximately 2 to 6 months after delivery. Several attempts are made to contact the mother by mail. If that fails, the mother is contacted by telephone, and an attempt is made to interview her. The survey questionnaire is linked back

to a select set of items from the birth certificate. The overall data are statistically weighted to adjust for the survey design, noncoverage, and nonresponse.

The current study used multiple years of data (1995 to 1998) from 13 states (n=58,625 births), with response rates ranging from 68% to >80%. Data from Alabama, Alaska, Arkansas, Colorado, Florida, Georgia, Maine, New York (excluding New York City), North Carolina, Oklahoma, South Carolina, Washington, and West Virginia were used. Because all of these states did not initiate data collection at the same time, earlier years of data did not exist for some states; for Georgia, no 1998 data were available. These states were chosen for analysis because they had the most years of data on folic acid awareness and adequate response rates to answer the research questions. To define the measures used in this analysis, questions from the Pregnancy Risk Assessment Monitoring System survey and specific variables from birth certificates were used. The primary measure -- folic acid awareness -- was defined as women's responses to the following question: â œHave you ever heard or read that taking the vitamin folic acid can help prevent some birth defects?â Response options were â œyesâ or â œno.â Reported race was classified as black, white, or other, and ethnicity was classified as either Hispanic or non-Hispanic. Education status was classified as less than high school, high school completion, or more than high school. Maternal age was divided into four categories (<19, 20 to 29, 30 to 39, and >40 years). Marital status was categorized as married or not married. Women who had more than 1 child were categorized as multipara, whereas those for whom the index birth was the first were categorized as primipara. Women who stated that they had insurance before they became pregnant were categorized as having insurance, and those who answered no were classified as not having any insurance before pregnancy. Women were asked what type of insurance paid for their prenatal care, with categories listed as Medicaid, private, and other. Enrollment in Medicaid or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) was categorized as a dichotomous variable. Choices for place of prenatal care were hospital, health department, private doctor, Indian Health Service or other federally funded program, and other. In addition to demographic, health-care provider, and insurance variables, this study also examined women's pregnancy intention status, timing of prenatal-care initiation, and whether the prenatal-care provider discussed nutrition and the baby's growth and development. Women's pregnancy intentions were divided into four categories; pregnancy was intended sooner, pregnancy was intended to occur at the time it did, pregnancy was intended for a later time, or pregnancy was not intended. Initiation of prenatal care was defined as entry into prenatal care during the first trimester or later/none. Women who had not obtained any prenatal care were put into the latter category. Whether women received professional advice on what to eat during pregnancy and whether their provider discussed fetal growth and development were defined as yes or no.

Perinatal Prevention Guidelines: A Multistate Surveillance Evaluation

State and local health departments that conduct surveillance of adult and pediatric HIV infection seek to identify perinatally exposed infants, collect demographic and clinical information (including HIV diagnostic tests, birth history, and maternal and new-born zidovudine receipt), and follow up with infants until sufficient laboratory information is available to classify them as infected or not infected, based on the recently expanded case definitions. The seven states that collected data on 1993

(i.e., the baseline year before publication of the 1994 findings of the Pediatric AIDS Clinical Trials Group 076 [PACTG 076] that zidovudine treatment of pregnant women and newborns reduced the risk for HIV transmission), 1995, and 1996 births were Colorado, Indiana, Louisiana, Michigan, Missouri, New Jersey, and South Carolina. All seven states had HIV reporting in place for at least 3 years before initiating the matching of case and birth registries and had required reporting of all prevalent HIV cases in adult and adolescent women when HIV reporting was implemented. Cases were ascertained by soliciting case reports from institutions and health-care providers as well as laboratory reports of tests diagnostic of HIV infection. Enhanced surveillance consisted of a) increased efforts to completely ascertain mother-infant pairs by matching birth registries to HIV/AIDS registries; and b) the abstraction of information on pairs from all available medical charts, including the mother's prenatal care chart, HIV clinic chart, labor and delivery chart, the child's birth chart, and the child's HIV clinic chart. The information collected included not only the information required for the surveillance case report form but more detailed information on prenatal care, illicit drug use during pregnancy, additional information on zidovudine prescription, reasons for discontinuing zidovudine, characteristics of labor and delivery, and the mother's disease status.

In the participating states, birth registries for 1993, 1995, and 1996 were matched to women reported with HIV/AIDS. HIV-infected women in the mother-infant pairs were considered to have received the diagnosis before delivery if the date of their first HIV-positive test result (in the HIV/AIDS registry) preceded the child's date of birth. The number of HIV-infected women who gave birth during each year and whose HIV infection had been diagnosed before delivery was derived from the total number of matches (including previously identified mother-infant pairs and pairs identified through the registry match) provided. The estimated total number of HIV-infected women who gave birth each year was obtained from the Survey of Childbearing Women (SCBW) when available. The Survey of Childbearing Women was an anonymous population-based seroprevalence survey of routinely collected blood specimens from newborns tested for maternal HIV antibody. New Jersey and South Carolina had Survey of Childbearing Women data for 1993 to 1996; Colorado, Michigan, and Louisiana had data for 1993 to 1995; Missouri for 1993 and 1994; and Indiana for 1994. Data from the most recent year were used when data were not available for a given year. These seven states represented approximately 15% of HIV-infected women who gave birth nationwide in 1995.

Supplemental Data Collection

In six of seven states (all except New Jersey), all HIV-infected women who gave birth during 1993, 1995, and 1996 and whose HIV infection was diagnosed before delivery, and whose children were born during those years were eligible for supplemental chart abstraction. In New Jersey, because of the large number of mother-infant pairs, supplemental data in 1993 and 1996 were limited to women who gave birth during July through December of those years; for 1995, all pairs were eligible. Thus, the total number of pairs eligible for chart abstraction was smaller than the total number of women with diagnosis before delivery. Supplemental data were also collected for mother-infant pairs where mothers were tested at or after delivery.

Classification of HIV Exposure Category for Women without HIV Risk Information

All states and territories in the United States report cases of AIDS to the Centers for Disease Control and Prevention (CDC) through the HIV/AIDS Reporting System (HARS); as of December 1999, a total of 33 states and territories also report cases of HIV infection without AIDS. HIV and AIDS cases are reported to state health departments, which forward the data to the Centers for Disease Control and Prevention with no personally identifying information. The Supplement to HIV/AIDS Surveillance (SHAS) is a surveillance project in which persons who have been reported to state or local health departments in 12 states are interviewed using a standardized, confidential questionnaire. Participants must be aged $\geq$18 years, give consent, and be able to complete the interview. The Supplement to HIV/AIDS Surveillance has been ongoing since 1990. Data from HIV/AIDS Reporting System and the Supplement to HIV/AIDS Surveillance are linked by using an identification number assigned by the state health department.

Data from women who completed a Supplement to HIV/AIDS Surveillance interview from January 1993 through December 1996 were analyzed. The analysis was restricted to women with a diagnosis of HIV infection (not AIDS), regardless of when they learned of their diagnosis, and women who had learned of their AIDS diagnosis within the 12 months before the interview. Women whose exposure risk category was transfusion or hemophilia were excluded because these categories account for a small proportion of cases. Trained interviewers administered a 45-minute standardized questionnaire to eligible persons who gave oral consent to be interviewed. The instrument included, but was not limited to, questions regarding sociodemographics, sexual behaviors during the previous year, and substance use during the previous 5 years. Each health department ensured privacy during the interview. The Supplement to HIV/AIDS Surveillance project was approved by local human subjects review boards. Names and other personal identifiers were removed before data were sent to the Centers for Disease Control and Prevention.

The variables for exposure risk category used in the guideline analysis came from the HIV/AIDS Reporting system. In most instances, exposure risk information in the HIV/AIDS Reporting System came from medical records; however, in some states, risk information obtained during the Supplement to HIV/AIDS Surveillance interview might be used to determine exposure risk category for cases initially reported without exposure risk information. The race/ethnicity variable also came from the HIV/AIDS Reporting System. Behavioral and demographic data that were used as independent variables in the model to predict exposure risk category came from the Supplement to HIV/AIDS Surveillance. A history of the following behaviors and diseases was examined: crack use (previous 5 years, >5 years ago, or never); noninjection-drug use, including crack but excluding marijuana (previous 5 years); sexually transmitted disease (previous 10 years); alcohol abuse; exchange of sex for money or drugs (previous 5 years); and number of male sex partners (previous 5 years). Demographic variables that came from the Supplement to HIV/AIDS Surveillance were age, years of education, household income in the previous year, employment status, year of interview, disease status (AIDS or HIV infection) at the time of the interview, and region of the country where the person lived at the time of the interview.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Folic Acid Awareness

Software for Survey Data Analysis (SUDAAN) (Version 7.0; Research Triangle Institute, Research Triangle Park, North Carolina) was used for data analysis to ensure that the standard error estimates reflected the Pregnancy Risk Assessment Monitoring System survey design. Multiple logistic regression was used to examine overall gaps in folic acid awareness.

Classification of HIV Exposure Category for Women without HIV Risk Information

The chi-square test was used to assess the bivariate relation between each of the independent variables and exposure risk category. Discriminant function analysis was used to classify respondents by exposure category using SPSS version 7.5. Variables were entered into the analysis using a backward elimination procedure to select a minimum subset of predictors. Data from the interview and case report form were used to predict membership in three exposure risk categories (injection-drug users, heterosexual contact, and no reported risk). The data were randomly split into two parts with an equal number of observations in each. With one part of the data, a discriminant function analysis was conducted to identify the classification model, which was then applied to the other part of the data to classify exposure risk category. These analyses were conducted repeatedly using split random samples. The overall correct classification never varied more than two percentage points for any of the randomly generated split samples; the data from one analysis are presented in the guideline document.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Not stated

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Excerpted by the National Guideline Clearinghouse (NGC):

I. Folic acid awareness

All reproductive-aged women, including uninsured women, should be provided the opportunity to discuss proper nutrition with their primary care providers before conception.

The results of the Pregnancy Risk Assessment Monitoring System (PRAMS) study could be used to promote healthier pregnancies by encouraging: (a) more prepregnancy planning, (b) greater consumption of diets rich in vitamins (including folic acid) and mineral by women, and (c) increased preconceptional health education for all women of reproductive age. Given the observed increase in women's awareness regarding folic acid over several years, particularly after the implementation of major national and state efforts, the Centers for Disease Control and Prevention recommends that health education efforts continue and expand on multipronged strategies to reach women in low socioeconomic and cultural groups. Specific messages and avenues of communication (e.g., media, interpersonal) for women in racial and ethnic groups should be identified and mobilized. In addition, health-care providers in general and prenatal care providers in particular should take advantage of every preconceptional and early prenatal encounter to educate women and their families regarding pregnancy planning to ensure optimal pregnancy outcomes for women and infants. Also, comprehensive reproductive health policies that provide resources and opportunities for both men and women to make optimal preconceptional decisions should be implemented by health-care providers.

II. Perinatal Human Immunodeficiency Virus (HIV) Prevention

Zidovudine, used for treating pregnant HIV-infected women, has been rapidly adopted in clinical practice and has reduced the transmission of HIV. To achieve continued declines in perinatal transmission of HIV infection, continued progress is needed in the following areas: (a) increases in the proportion of women who receive prenatal care and an HIV diagnosis; and (b) implementation of rapid testing methods (when licensed rapid tests are available) or rapid turnaround of standard tests (expedited enzyme immunoassay tests).

III. A Method for Classification of HIV Exposure Category for Women Without HIV Risk Information

Exposure risk information is used to monitor trends in routes of HIV transmission, to plan prevention programs, and to allocate resources to priority populations at risk for HIV infection. However, with an increasing proportion of cases reported with no exposure risk information, statistical adjustments must be made to the surveillance data to monitor trends. Findings in this report indicate that a statistical model based on data reported in interviews and case report forms of persons with HIV/AIDS can be used to classify most cases among women into the same exposure risk category recorded on their case report form (see original guideline for details). In addition, the model can classify nearly all cases among women reported without risk. Behaviors, including crack use, other noninjection-drug use, and alcohol use, were stronger predictors of exposure risk category than demographic characteristics. These findings emphasize the need for behavioral surveillance to improve HIV prevention planning at the state and local levels.

The findings indicate that use of crack and other noninjection-drugs was more prevalent among injection-drug users than among women in the heterosexual contact exposure category (see Table 1 in the original guideline document). Crack is a risk for heterosexual transmission of HIV because of its relation with risky sexual behaviors. Injection-drug use in combination with crack use has also been associated with a higher prevalence of risky sexual behaviors. Given that the model in this report would likely classify crack users into the injection-drug use exposure category, rather than the heterosexual contact category, the link between crack use and heterosexual transmission of HIV should be further explored.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Folic Acid Awareness

Recommendations are based on analysis of the Pregnancy Risk Assessment Monitoring System Data (PRAMS) for 1995-1998.

Perinatal Human Immunodeficiency Virus (HIV) Prevention

Recommendations are based on analysis of the state health department HIV/AIDS registries.

Classification of HIV Exposure Category for Women without HIV Risk Information

Recommendations are based on an analysis of data obtained from the HIV/AIDS Reporting System (HARS) and the Supplement to HIV/AIDS Surveillance (SHAS) project.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Folic Acid Awareness

Analysis of study results from the Pregnancy Risk Assessment Monitoring Systems (PRAMS) study showed overall folic acid awareness increased 15%, from 64% in 1996 to 73% in 1998, although changes varied by state. Women's awareness regarding the benefits of folic acid particularly increased after the implementation of major national and state health promotion efforts.

Benefits of Folic Acid in Preventing Birth Defects

Periconceptional intake of 0.4 mg of the B vitamin folic acid reduces the risk for neural tube defects 50% to 70%.

Benefits of Zidovudine

Zidovudine has been used successfully to reduce perinatal transmission of HIV infection.

Benefits of Surveillance Systems and Classification Models for HIV Prevention

The use of surveillance systems and classification models can help states analyze and interpret HIV/AIDS trends, as well as plan prevention and other program services to address important public health problems.

Multistate Surveillance Evaluation for Perinatal HIV Prevention Guidelines

From 1993 through 1996, the proportion of HIV-infected women with diagnosis before delivery increased from 70% to 80%. The proportion of women with a diagnosis who received zidovudine prenatally increased from 37% to 83% and intrapartum, 6% to 75%; for neonates, the increase was from 8% to 77%. Overall, 14% of women received no or only one prenatal care visit. A total of 36% of women who used illicit drugs during pregnancy had not had prenatal care. Of

the children who received any zidovudine, 8% were infected compared with 16% of those who received no zidovudine.

Classification of HIV Exposure Category

As a result of the classification procedure using discriminant function analysis, nearly all cases among women with no reported risk were classified into an exposure risk category.

Subgroups Most Likely to Benefit:

Folic Acid Awareness

Women who are less aware of folic acid are most likely to benefit from the recommendations. In the study, the following groups of women were less aware of folic acid: (1) women who obtained a high school education or less; (2) who were black, Hispanic, or from other racial/ethnic groups; (3) women who entered prenatal care after the first trimester; and (4) women whose pregnancies were unintended.

Perinatal HIV Prevention

Women who use drugs during pregnancy disproportionately receive inadequate or no prenatal care. Targeted interventions are begin implemented to increase access to care and testing in these women.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Folic Acid Awareness

Although the Pregnancy Risk Assessment Monitoring System (PRAMS) study will be useful for promoting specific targeted efforts, several limitations exist. First, this research focuses on women's awareness, and no behavior data were available to assess folic acid awareness. Other studies of folic acid awareness and consumption have demonstrated a substantial gap between folic acid awareness and consumption behavior. Second, data from the Pregnancy Risk Assessment Monitoring System could be biased because its surveys are administered after the birth of an infant, creating a time lapse since early pregnancy when women might have learned about folic acid. Third, the format of the Pregnancy Risk Assessment Monitoring System survey does not measure whether responders know how much folic acid to take or that they need folic acid before and during the earliest days of pregnancy.

Perinatal Human Immunodeficiency Virus (HIV) Prevention

These data have several limitations. First, uncertainty regarding the number of HIV-infected women who gave birth during 1996 in most states that lacked Survey of Childbearing Women (SCBW) data is a limitation. Using 1995 data as a proxy for 1996 might systematically bias the results. For example, if the number of infected women giving birth in 1996 was larger than in 1995, the calculated percentage tested would be too small or vice versa. In addition, state-level fluctuations were observed, especially in states with smaller numbers of infected women; therefore, the aggregate estimate is likely more stable than state-level estimates. Second, the proportion of infected women with a diagnosis before delivery might be an underestimate because women who had not been reported could not be included in the registry matching. Second, the proportion of infected women with a diagnosis before delivery might be an underestimate: although the completeness of HIV reporting is estimated to be >85%, women who had not been reported could not be included in the registry match. Third, supplemental information could be collected only on 86% of the charts eligible for review. Women whose charts were not abstracted because they were more difficult to find possibly were less likely to have received zidovudine. Finally, supplemental data were incomplete for the pairs with mothers who were tested at or after delivery.

A Method for Classification of HIV Exposure Category for Women Without HIV Risk Information

The self-reported data from Supplement to HIV/AIDS Surveillance might be biased by recall or social desirability, which might result in over or underreporting of risk behaviors. During the study period in which the proportion of cases reported without exposure information was lower, some states updated a small proportion of HIV/AIDS Reporting System records with data obtained from Supplement to HIV/AIDS Surveillance. Thus, the findings in this report might overestimate the proportion of cases â œcorrectlyâ classified. HIV/AIDS Reporting System data abstracted from medical record review might be biased by what healthcare providers document or how the record abstractor interprets the documentation. Without a reference -- for example, knowing whether self-report or chart review provides more accurate and valid risk data -- a comparison of results can only be made from different methods of adjusting risk and deciding which methods are best from a practical point of view. Thus, the reference might be a combination of interview and chart review cross-validated with biological tests (e.g., testing for sexually transmitted diseases, including HIV). If exposure risk information was obtained from Supplement to HIV/AIDS Surveillance interviews and from medical chart reviews on a representative sample of cases in all states with high or moderate prevalence of HIV, an accurate probability distribution for exposure risk category for HIV infection at the state and national levels could be produced.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Perinatal HIV Prevention

Continued increases in the proportion of women who receive effective antiretroviral therapies will be necessary to further reduce perinatal transmission

and will depend on the success of efforts to increase testing, access to and use of prenatal care, and the use of rapid testing and short-course treatments for women who are first seen in labor. Because women who use drugs during pregnancy disproportionately receive inadequate or no prenatal care, targeted interventions such as community-based outreach are being implemented in 16 states to promote increased access to care and testing among pregnant women who might not otherwise receive prenatal care.

To monitor the outcomes of perinatal testing and treatment programs, enhanced perinatal surveillance is needed in all states to assess perinatal prevention needs and to monitor the effect of prevention programs. Enhanced surveillance, initially conducted in the 7 states mentioned in this report, has recently been extended to 22 states in conjunction with a Centers for Disease Control and Prevention initiative to eliminate perinatal transmission of HIV. The surveillance system can adapt rapidly, providing an efficient means of collecting relevant information as clinical developments occur. As the perinatal transmission of HIV continues to decrease, surveillance data will continue to play a central role in specifying the reasons for continuing transmission and in identifying the areas where transmission continues.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

CDC report regarding selected public health topics affecting women's health. MMWR Recomm Rep 2001 May 11;50(RR-6):1-48. [79 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 May 11

GUIDELINE DEVELOPER(S)

Centers for Disease Control and Prevention - Federal Government Agency [U.S.]

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

None stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

"Are Women with Recent Live Births Aware of the Benefits of Folic Acid?" - Authors: Indu B. Ahluwalia, MPH, PhD, Division of Reproductive Health National Center for Chronic Disease Prevention and Health Promotion; Katherine Lyon Daniel, PhD, National Center on Birth Defects and Developmental Disabilities

"Successful Implementation of Perinatal HIV Prevention Guidelines" - Authors: Pascale M. Wortley, MD, MPH; Mary Lou Lindegren, MD; Patricia L. Fleming, PhD, MS; Division of HIV/AIDS Prevention — Surveillance and Epidemiology National Center for HIV, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention

"A Method for Classification of HIV Exposure Category for Women Without HIV Risk Information" - Authors: Amy Lansky, PhD, MPH; Patricia L. Fleming, PhD, MS; Robert H. Byers, Jr, PhD; John M. Karon, PhD; Pascale M. Wortley, MD, MPH; Division of HIV/AIDS Prevention, Surveillance and Epidemiology National Center for HIV, STD, and TB Prevention

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: HTML files are available from the Centers for Disease Control and Prevention (CDC) Web site, as follows:

- Foreword
- Are Women with Recent Live Births Aware of the Benefits of Folic Acid?
- Successful Implementation of Perinatal HIV Prevention Guidelines
- A Method for Classification of HIV Exposure Category for Women Without HIV Risk Information

Also available in Portable Document Format (PDF) from the Centers for Disease Control and Prevention (CDC) Web site

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on October 8, 2001.

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